Client intake form

Today's date_____

Client's Name_____ Age_____ Birth date_____

Parents/Guardian's Name (s)_____

Address_____

Phone (cell)_____ Home_____ Work_____

E-mail_____

Marital Status: ❑ single ❑ engaged

❑ married (how long_____; times Married_____)

❑ separated (how long_____) ❑ divorced (how long_____)

Education_____ Occupation_____

Spouse's name_____Age_____ Birth date_____

Spouse's Occupations_____

List name, birth date, sex, of all children and whether they live at home with you

Name	Birth date	Sex	Relationship	At home?

Who is coming for counseling? _____Any prior counseling ❑ yes ❑ no

If yes, When?_____ Where?_____ With Whom?_____

Why?_____

Are you, or another family member, currently seeing a psychiatrist or another counselor? ❑ Yes ❑ No

If so, what family member?_____ Name of helper_____

For what purpose?_____

Person to contact in emergency (name, relationship, phone, address_____

_____

PLEASE FILL OUT THE FOLLOWING INFORMATION AS IT APPLIES TO THE CLIENT

State the nature of the problem in your own words:_____
_____
_____

What is your most difficult relationship now?_____ best?_____

What is your most difficult emotion now?_____ best?_____

CRISIS INFORMATION: Any current suicidal thoughts, feeling, or actions?

❑ Yes ❑ No If yes, please explain_____

Any current homicidal or violent thoughts, feelings, or anger control problems?

❑ Yes ❑ No If yes, please explain_____

Any past problems, hospitalizations, or jailing for suicidal or violent behavior?

❑ Yes ❑ No If yes, please describe_____

Any current threats of significant loss or harm(illness, divorce, custody, job loss, etc.)?

❑ Yes ❑ No If yes, please describe_____

MEDICAL INFORMATION: Doctors name, address, and phone_____
_____

Are you presently taking any medication? ❑ Yes ❑ No If yes, What?_____

For what purpose_____

Any problems with:❑Eating ❑Sleeping ❑Chronic pain ❑Recent weight changes

Describe any answers checked above:_____

Any other medical problem?_____

Have you or a family member ever been hospitalized for mental or emotional illness?

❑ Yes ❑ No If yes, please explain-dates, place, reason_____
_____

Common problem/symptom checklist Fill in: 0=none 1=mild 2=moderate 3=severe

__marriage	__divorce/separation	__alcohol/drugs	__God/faith
__Premarital	__child custody	__other addictions	__church/ministry
__singleness	__disabled	__grief/loss	__past hurts
__sexual issues	__work/career	__depression	__codependency
__family	__school/learning	__fear/anxiety	__intimacy
__children	__money/budgeting	__anger/control	__communication
__parents	__aging/dependency	__loneliness	__self-esteem
__in-laws	__weight control	__mood swings	__stress management

Other (specify):_____

Who referred you to me? (name, relationship, and phone number) _____